EXECUTIVE SUMMARY

INTRODUCTION

This first edition of the Health Care Safety Net Administration (HCSNA) Annual Report provides an overview of the vision, goals, and progress made during our first year of serving the community.

The District of Columbia's leadership and the Department of Health (DOH) have nurtured for years a vision of a safety net healthcare system that would significantly improve the health of the District's uninsured low-income residents. A system that, in doing so, would enhance the quality of life of all people living and working in the District of Columbia. This system would shift the focus of treatment away from the city's hospital emergency rooms (ER) and eliminate the barriers preventing access to primary care and preventive health services. To this end, the District of Columbia government has laid the foundation to transform its public healthcare delivery system, and it is our challenge to bring it forward into the 21st century.

HEALTH REFORM INITIATIVE

In October 1999, Mayor Anthony Williams, together with Council Chair Linda Cropp and Human Services Committee Chair Sandra Allen, convened the Health Care System Development Commission to recommend strategies to overhaul the District's public healthcare system and to increase access to services. By the middle of the following year the Council approved the Commission's recommendations, which became the basis for the Mayor's overall plan to restructure the District's healthcare system for its most needy residents. When the Mayor included it in his FY 2002 budget proposal, the program moved another step closer to reality.

On April 21, 2001, the cornerstone of the DC Health Services Reform (HSR) Initiative was put into place with the formation of the HCSNA. The basis for the mandated functions of HCSNA and the formation of the DC Healthcare Alliance was established with the passage of the Healthcare Privatization Act of 2001. The Alliance represents an innovative approach to public health, as a public-private partnership between Greater Southeast Community Hospital Corporation (GSCHC), the prime contractor, and the DC Department of Health. GSCHC partnered with five other private sector providers in this effort to create the kind of comprehensive healthcare program requested in its contract. These initial partners, Chartered Health Plan, Unity Health Care, Children's National Medical Center, The George Washington University Hospital, and Providence Hospital, created the Alliance healthcare network. However, with this contract came new responsibilities for the Department of Health to monitor the system of care that was put into place. It was a challenge that would be the focus of the HCSNA.

To monitor the transition, implementation, and operation of the Health Services Reform Initiative, as well as to serve as a collaborative advisory body for the HCSNA, the Health

Services Reform Commission was established through a Mayoral Order on May 16, 2001. The Commission also provides guidance to the Mayor and the Chief Health Officer of the District of Columbia on the progress and emerging challenges as the District's healthcare delivery system evolves.

THE DC HEALTHCARE ALLIANCE

In recent years, a trend has emerged for large urban centers to embrace privatized programs to support and manage healthcare for their uninsured residents. While these public and private alliances are generally structured differently than the DCHCA, the intent to shift medical care from an emergency room and acute care setting to community-based health clinics and primary care physicians is the underlying philosophy shared by each. Lessons learned from these early partnerships, as well as knowledge accumulated over the years of serving the uninsured population in the District, have charted the course for HCSNA's oversight strategy and planning efforts.

The creation of the DC Healthcare Alliance brought with it many of the private sector philosophies and methods for managing healthcare that maximize the use of resources while enhancing quality of care. It brought a new focus on primary care and preventive programs with a primary care physician acting as the patient's agent to manage the spectrum of services available within the program. It enabled chronic disease management programs to be implemented so that potentially high-cost medical conditions could be managed and unnecessary hospitalizations avoided. In addition, it added an element often lacking in public health programs. It introduced patient satisfaction as a measure of the quality of care that was being provided. These programs now form the core of the healthcare delivery system for the District of Columbia's uninsured poor residents.

The challenge of creating a system that would increase access, ensure quality, and improve health outcomes resulted in the following improvements:

- A new service delivery structure that uses a patient-centered care model as a guiding principle for care
- A new program that targets resources and services to the people for which the program is intended, the District's poor uninsured residents
- A new and expanded array of service delivery sites that includes 6 network hospitals, 28 neighborhood clinics, and 781 primary care providers and specialists
- A new and extensive network of hospitals and emergency services that coordinates services with each member's medical home and their Primary Care Provider (PCP) for continued focus on primary care and disease prevention
- An improved system for data collection and reporting that provides information on the disease status, treatment plan, cost of treatment, and use of services provided through the Alliance.

We are proud of HCSNA's achievements in its first year of operation. As we move into the second year, we have built a team of dedicated health professionals who will strive to improve and oversee this new healthcare delivery system.

THE SAFETY NET TEAM

As a newly created division of the DC DOH, the Health Care Safety Net Administration has taken giant steps toward becoming a fully staffed administrative unit. To accomplish our goals, four new offices were created:

- The Office of the Deputy Director provides overall program leadership and policy direction to HCSNA and the Alliance.
- The Office on Quality Assurance and Improvement provides direction on ensuring and improving the quality of healthcare provided through the Alliance contract.
- The Office on Community Health Systems provides direction for creating an integrated healthcare delivery system, with special emphasis on access to care, management of information systems, standardization of data, reporting across the network, and improving provider, member, and other stakeholder satisfaction.
- The Office on Financial Management provides direction on cost containment measures for the HCSNA.

THE STRATEGIC PLANNING PROCESS

To be effective in its first year of implementation of the Alliance Program, HCSNA formulated a plan that would encourage strategic thinking and activities among its staff. The plan seeks to strengthen HCSNA's position by understanding the environment in which it operates. Six strategic goals were identified during the creation of this plan. Distinct objectives and action steps were identified for each goal. The staff also developed a mission, vision, and values statement that would guide the administration in years 1 and 2.

HCSNA spent its first year implementing the objectives stated in the strategic plan. The HCSNA Business Plan outlines the progress made in accomplishing each goal. As we move into our second year, we have successfully realized more than 60 percent of our goals and objectives.

HCSNA ACTIVITIES AND RESPONSIBILITIES

With the increased public awareness that significant variations exist in the quality of care between healthcare systems and that many provide suboptimal care, there has been an increased emphasis on reporting of quality and effectiveness of care. As with the implementation of any new healthcare system, the need to measure progress and validate the effectiveness of the Alliance program was identified as a critical factor from the beginning.

The oversight and monitoring activities of HCSNA are at the heart of its responsibilities. These activities are listed in detail in the "HCSNA Monitoring and Evaluation Manual," which also provides specifics about the contract compliance terms and methods for the review process.

HCSNA developed and implemented an Operational Oversight Committee and five subcommittees consistent with its strategic plan. The Committee and subcommittees are composed of key individuals from the DC Healthcare Alliance and the Department of Health. The purpose of these subcommittees is to serve as a vehicle for information dissemination and oversight of the Alliance contract.

Data and Reporting Oversight Subcommittee—Addresses data collection, aggregation, standardization, and reporting issues.

Public Information Oversight Subcommittee—Provides oversight of the Alliance communications and public relations efforts.

Information Technology Oversight Subcommittee—Responsible for information technology to enable a patient-centered approach for care delivery.

Quality of Care Oversight Subcommittee—Provides a forum for collaboration between clinical staff across the Alliance partners and the HCSNA to review quality and coordination of care issues, and to identify and resolve issues impacting patient care.

Customer Service/Provider Satisfaction Oversight Subcommittee—Provides oversight and monitoring on matters pertaining to customer service and provider satisfaction. This includes a program wide customer and provider satisfaction system that identifies all complaints, and praises and ensures that all issues are directed to the appropriate partner for a timely resolution.

EARLY MONITORING SYSTEM

The HCSNA reporting and monitoring efforts started with the development of an early monitoring system that used clinical utilization and operational information from existing data sources to monitor performance of the program. This formed the basis for providing real-time assessments of operational and clinical performance and reports summarizing this information for key stakeholders, such as the Alliance Management, the Mayor's Office, and the Commission.

FOCUSED QUALITY OF CARE STUDIES

A need exists to obtain targeted information on specific clinical issues of concern. Because information was not available through the initial data systems, it required focused quality of care studies involving medical chart reviews. Some of the studies performed in the initial months of the program were focused on perinatal care services and on inpatient care management and discharge planning.

MONITORING AND EVALUATION

HCSNA developed a system that ensures accountability among its healthcare delivery system providers. Contractual compliance is monitored through on-site and administrative reviews.

The comprehensive contract compliance manual was developed to guide HCSNA staff in performing their oversight and monitoring responsibilities.

ADMINISTRATIVE SERVICES ANALYSIS

HCSNA developed and conducted the Alliance Administrative Services Analysis in the form of a desk audit and onsite assessment. This analysis is limited to the priority functions of eligibility, enrollment, and claims processing.

MAINTENANCE OF EFFORT

HCSNA defined baseline levels of charity care required by legislative mandate of all District of Columbia hospitals and clinics. The purpose of these baseline levels is two-fold: (1) to ensure that the healthcare providers continued to meet their mandated charity care obligations as required under the State Health Care Planning and Development Agency (SHPDA) statutes; and (2) to ensure that the providers be fairly compensated for the healthcare services delivered to the District's eligible uninsured residents who are above their required charity care levels.

FINANCIAL RECONCILIATION

HCSA oversees a review of the GSCH's compliance with the terms and conditions as stated in the agreement between the District and GSCHC. The purpose of this function is to:

- Ascertain if payments made were in accordance with the rates for healthcare services as set forth in the agreement
- Compute budget reconciliation and other adjustments that are periodically required by the agreement.

ALLIANCE DATA WAREHOUSE PROJECT

Mercer Government Human Services Consulting (Mercer) and the DOH are in the process of transitioning the data warehouse from Mercer's operational control to DOH operational control.

PERFORMANCE MEASUREMENT SYSTEM

Core system performance indicators were identified from each of the following broad operational categories. They are:

- Access to care
- Quality of care
- Utilization of services
- Financial performance

- Customer/provider satisfaction
- Management/administrative performance.

In each of these categories, core performance indicators were selected. As appropriate, nationally established measures were selected to ensure validity and that benchmark data is available to compare Alliance performance against national and regional best practices.

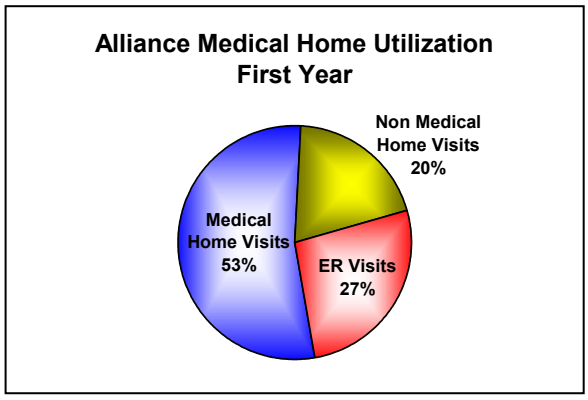
OUR PROGRESS

During a demanding first year for the Alliance program most of the activities focused on the development of the infrastructure required for effective and efficient care. However, HCSNA, in collaboration with the Alliance partners, has been actively measuring the performance indicators in each of the six broad operational categories. The results that are currently available are presented in this report. These results cover the first 10 months of the Alliance program and were derived from multiple data sources such as Alliance service reports, Alliance claims reports, and the HCSNA data warehouse.

ACCESS TO CARE

In the initial year of the program, access to care was assessed by monitoring the counts of primary care and specialist providers in the network in relation to the total enrollment.

- Every documented member of the Alliance was assigned a primary care provider. This meant assignment of 253 primary care physicians to 27,364 members and a ratio of one PCP for every 108 enrollees. Additional PCP workload measures will be developed to account for physicians serving patients outside the Alliance.
- Geospatial analysis indicated that primary care physicians were appropriately located where the density of Alliance membership was the greatest.
- In the first year of operation, 100 percent of documented Alliance members were assigned to a PCP/medical home.
- Enrollees received 54 percent of all provider services at their medical home.
- Treatment for the top 10 most common diagnoses from paid claims for the first year was predominantly provided at the enrollee's medical home.

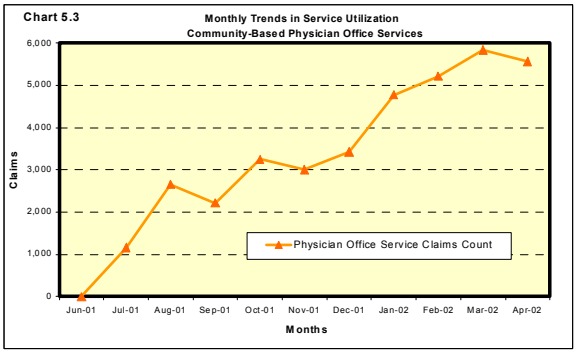


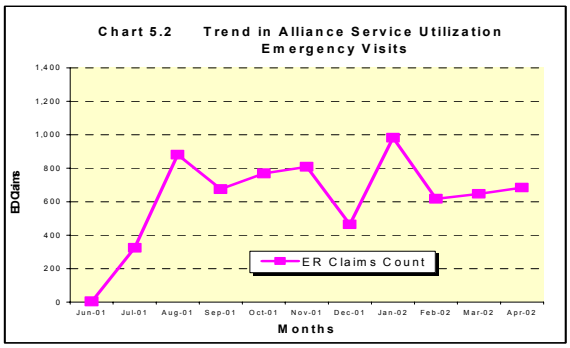
- The average number of enrollees for each specialist serving Alliance patients varied by specialty category depending on the frequency that these specialists are needed. Ratios ranged from 339 enrolles per surgical subspecialist to 2,596 enrollees per dermatologist.
- The volume of clinic services at the DC General clinics for the first year of Alliance operations generally compared favorably with baseline data for the previous year where the clinics were operated by the PBC. There were significantly fewer surgeries, but this may reflect a shift to other providers in the network.
- Trauma services have been expanded from DC General to include George Washington University Hospital, Children's NMC, Providence, and Howard University Hospital.
- Waiting times from triage to disposition declined steadily in the months following the ramp up of Alliance operations. The percent of ED patients having to wait more than 6 hours averaged about 6.4 percent at GSECH, and 13.8 percent at DC General. Both are approaching the Maryland Hospital Association's benchmark of 6.1 percent.

QUALITY OF CARE

Measurement of quality of care is complicated in the Alliance population where members frequently move in and out of the system due to changes in eligibility. For the initial phase of the Alliance program implementation, the focus was on developing an infrastructure for appropriate care delivery. Hence, most of the indicators that are being tracked are indicators of process. These numbers provide a baseline against which future performance can be measured. A listing of the quality measures results in the first year of operation follows:

- For every thousand enrollees in the Alliance, there were 912 visits to Alliance community clinics.
- Of a total of 46,810 outpatient visits, 54 percent were provided through the assigned medical home/PCP.
- For every 10 Alliance enrollees, there were approximately 3.3 visits to the emergency room during the year. This compares well with the most recent national rate of 3.9 visits for every 10 people in the general population, reported by the National Center for Health Statistics (NCHS) for 2000.
- The percentage of cholesterol screen tests performed among enrolled patients with cardiovascular disease was 13.4 percent for 6,478 patients with cardiac disease.
- The percentage of HbA1c tests performed among enrolled diabetics was 34 percent for 2,343 diabetics.
- The mammography rate in women 50 years or older was 14 percent for 4,469 women.
- The monthly average length of stay for Alliance inpatients declined over the first year of operations from 6.7 to 5.2 days. The average over the full year was 5.9 days per hospital stay. This is comparable to the 5.7 day average calculated for the DC Hospital Association's members in 2001.
- The rate of unscheduled hospital readmissions within 60 days of discharge was 11 percent for 1,628 inpatient discharges.





- The rate of inpatient discharges at Alliance hospitals per thousand Alliance enrollees was 43 per 1000.
- The monthly trend in visits to physicians offices increased steadily as shown in Chart 5.3. Concurrently, there was relative stabilization of ER utilization shown in Chart 5.2. This trend indicates that the Alliance is doing what was expected in shifting primary care to community primary care settings rather than to the District's ERs.
- On a scale of 0 to 10, the percentage of enrollees giving the program an overall satisfaction rating of at least an "8" was 71 percent.
- The percentage of enrollees that reported that the physician assigned to them met their cultural needs was 94 percent.
- The percentage of enrollees reporting in a survey that the care they received at their doctor's office was better than the care they received at an emergency room was 43 percent.
- The percentage of Alliance enrollees who stated they usually or always are able to get care quickly with some or little problems was 64 percent. This rate compares favorably with Medicaid managed care plans.

PROFILE OF ALLIANCE PATIENTS

- The Alliance is serving generally the same population as DCGH did in terms of age, gender, and location.
- The greatest percentage (47 percent) of Alliance enrollees was between the ages of 31 and 50.
- In the 18-30 age category, there were more Alliance females than males by approximately 3 percent.
- There were approximately an equal number of men and women enrolled in the Alliance.
- The majority of the Alliance population is clustered in 4 Wards: 8, 7, 1, and 6 as ranked highest to lowest.
- Wards 6 and 7 had membership that was roughly 25 percent and 30 percent lower than DCGH, respectively.
- Ward 8 had an Alliance membership that was 4 percent greater than the DCGH population.

- About three-fourths of the Alliance enrollees are African American or Black, whereas most of the remaining members are Hispanic (22 percent).
- The HCSNA now has the information to target specific populations and neighborhoods for outreach, enrollment, and disease and care management.

DISEASE PROFILE

- Hypertension was the major diagnosis within the Alliance adult population. As a disease category, it represented almost 20 percent of Alliance members who received services in year 1.
- Diabetes was the second most comon disease diagnosis within the Alliance. Over 7 percent of the Alliance population had the condition diagnosed, representing about 1,300 individual patient claims. This group accounts for about 15 percent of the Alliance inpatient stays and was one of the leading reasons for unscheduled inpatient readmissions.
- Dental diseases, including dental carries, pulpitis, and general periodontal disease occurred in over 15 percent of the Alliance enrollees served or almost 3,000 patients.
- Walk-in visit rates to dental clinics increased each month throughout the course of the first year.
- As of this report, 318 mammogram screenings for breast cancer and 177 PSA screenings for prostate cancer were performed. This represents about 1 percent of the enrolled eligible population.
- HIV is a key diagnosis of Alliance patients upon admission to the hospital, as well as a significant reason for unscheduled readmissions.

ALLIANCE SERVICES

- The DC Healthcare Alliance offers a comprehensive and unique benefit package to uninsured District of Columbia residents who meet eligibility requirements, which includes:
    1. Community-based primary care services
    2. Acute care services such as hospital inpatient, and emergency services
    3. Ancillary support services to include laboratory, pharmacy, and radiological services
    4. Care management support services encompassing case/disease management and health education.

- Partnerships with other DC organizations have been formed to provide healthcare services for the School Health Program and the Department of Corrections.

- Children's National Medical Center partnered to provide services for the School Health Nurse Program, giving access to 68,449 children from DC Public Schools and 4,216 children from DC Public Chartered schools.
- During the first year there were more than 171,941 School Health Suite encounters.
- School health nurses identified 186 pregnancies at the high schools and provided counseling and support to students and families.
- Greater Southeast Community Hospital provided healthcare services to the Department of Corrections including 232 inpatients stays, 239 outpatient surgical procedures, and 579 emergency room visits.

ALLIANCE OPERATIONS AND MEMBER UTILIZATION

- Statistics indicate that 21,679 of 37,614 Alliance members received healthcare services during the first year of operation. The overall Alliance healthcare service rate was 58 percent.
- The overall use of healthcare services by members of the Alliance for the first year of operation are comparable to the DC Medicaid program and several other State Medicaid programs.
- Females used 53 percent of the total healthcare services provided by the Alliance, whereas males used 47 percent of the total services.
- The Alliance made major strides in collecting data on enrollment and utilization.
- During the first year of operation, the Alliance network expanded to include 6 network hospitals, 28 neighborhood clinics, and 781 primary care providers and specialists.

Outpatient Care

- Outpatient (OP) physician providers supplied 28 percent of Alliance healthcare services.
- The $3,932,215 paid for primary care services represented 13.8 percent of the total paid for all healthcare services in the first year.
- Unity Health Care, Inc. provided 70 percent of all paid outpatient services, and GSCH/DCGH Specialty Clinics provided an additional 17 percent.
- Every member of the Alliance was assigned to a primary care provider, which mean assignment of 253 primary care physicians to 27,364 members for an average of about 100 patients per physician.

Specialty Care

- Outpatient specialty care providers supplied 24 percent of all outpatient services in the first year of Alliance operations.
- The $2,649,968 paid for specialty care services represented 9 percent of the total sum paid for all healthcare services in the first year.

Inpatient Care

- The inpatient services (2,128 discharges) provided to Alliance patients in the first year represents 1.3 percent of the total annual paid healthcare service claims.
- The $16,659,687 paid for inpatient claims represents 49 percent of the sum paid for all healthcare service claims in the first year.
- The average length of inpatient stay for Alliance members was 6.7 days. This stay was higher than the historical rate for DC General Hospital; however, the lower rate of the Alliance could be attributed to a shift of inappropriate admissions, which generally are of short duration, to outpatient settings.
- The monthly average length of stay for Alliance inpatients declined over the first year of operations from 6.7 to 5.2 days. The average over the full year was 5.9 days per hospital stay. This is comparable to the 5.7 day average calculated for DC Hospital Association's members in 2001.
- The top three disease conditions, for both male and female inpatients, were hypertension, heart disease, and pneumonia.

Emergency Department Care

- There were 15,040 emergency department claims representing 9.4 percent of the total annual paid healthcare claims in the first year of Alliance operations.
- The $4,472,982 paid for emergency department claims represented 13 percent of the sum paid for all healthcare service claims in the first year.
- The use of the Emergency Department (ED), as measured by claims per enrolled member, was about 3.3 claims per 10 members. This compares favorably with an ED use rate of 2.6 per 10 members reported by the Buncombe County safety net program.

Dental Care

- There were 8,161 dental claims representing 5.1 percent of the total annual paid healthcare claims in the first year.
- The $983,251 paid for dental claims represented 2.9 percent of the total paid for all healthcare service claims during the year.
- About 66 percent of the dental services provided were for routine screening care.
- Tooth extractions accounted for 13 percent of the total dental services provided.

Pharmacy Service

- Access to pharmacy was dramatically improved in the first year of operation. Pharmaceutical services are administered by Unity Health Care and are available at six sites: DC General, Southwest, Anacostia, Hunt Place, Congress Heights, and Walker Jones.
- The Alliance experienced a steady increase in use in its first year when it filled 183,943 prescriptions, as compared with 167,828 prescriptions processed by the PBC during the same period one year earlier.
- There was an average of 497 more patients served each month and about 11 percent more prescriptions processed than in the previous year under the PBC.

- Significant improvements that were made during the year included increasing the hours of operation to include holidays, and expanding the drug formulary.

PRESUMPTIVE ELIGIBILITY (PE) VERSUS FULL ENROLLMENT

- Overall, the PE members appear to be sicker and to receive more care for their illnesses.
- During the first year, 37,614 members were enrolled and 10,406 were given presumptive eligibility status.
- Of the 10,406 presumptive members, 4,615 were distinct individuals receiving one or more services.
- There were 12,448 claims received for 4,615 distinct Alliance members, resulting in an average of 2.7 claims per member.
- The most significant disease distinctions between the presumptive and documented enrollees were demonstrated in the chronic illness groups.
- Hypertension was the most common condition regardless of category of enrollment.
- Ambulatory disease conditions such as cocaine abuse, acute pharyngitis, and UTI appeared to be more prevalent in the PE population.
- The PE enrollees tended to use the emergency department and inpatient services more than documented enrollees.
- The PE enrollees received fewer outpatient (diagnostic) and dental services. This is likely to be a contributing factor to greater dependence on inpatient and emergency services.
- Inpatient services made up 14 percent more of the paid services for PE members than documented members.
- The percent of total claims volume for physician services was nearly 70 percent, whereas the percent of physician services paid was only 17 percent.
- Generally, the demographic profile of the PE enrollees was the same as the documented enrollees.
- Ward 8 had nearly as many PE members as documented members, indicating a problem in getting documentation for these residents.
- In the 0- to 17-year-old age category, PE members outnumber the documented members by three to one. This is probably due in large part to children awaiting enrollment in Medicaid programs.

SUMMARY OF RECOMMENDATIONS: STRATEGIC PLANS

HCSNA Program Management

- Construct a performance based contract and implement contractual requirements with outcome targets identified for the vendor to achieve. Failure to reach the contractual goal or target will result in a diminished payment or withhold from the overall reimbursement.
- Eliminate the presumptive eligibility process for inpatient only and monitor ongoing cost to determine future actions.
- Implement a single point of entry process for application submission and eligibility determination.
- Develop and implement a retroactive payment process.

- Develop and implement a healthcare reimbursement recovery program. This recommendation contemplates payment recovery of those healthcare services that were paid incorrectly or erroneously.
- Provide HCSNA with the rule-making authority to enable it to create and amend regulations that govern the program.
- Provide HCSNA with budget authority to increase the program staff to meet the demands of the program. The total number of staff needed to monitor the contract is 25.
- Acquire immediate office space for nine new staff and four additional staff the following year.
- Cross-train staff to perform in more than one job.

Alliance Program Administration (changes to be implemented by vendor)

- Include the Department of Corrections members in the Eligibility File and track the Metropolitan Police Department claims by type of enrollee.
- Revise the stored electronic enrollment and eligibility data fields to track member employment, disability, race, etc.
- Implement a single point of entry process for application submission and eligibility determination. The Alliance will provide strict guidelines for enrollment processes including document verification, program screening, and management of eligibility exceptions populations.
- Provide access and training to the ACEDS System.
- Implement real-time electronic eligibility access for providers.
- Implement electronic data interchange for claims submission by providers and develop an integrated information system. This will allow for a system-wide Master Patient Index that will allow all Alliance member medical records to be accessed by providers at any point in the system.
- Develop a working definition for Medical Homes.

Quality of Care and Integrated Healthcare

- Secure a vendor to conduct chart audits of Alliance Quality of Care.
- Work with the Alliance to improve quality and accuracy of claims coding and reporting.
- Continue emergency department quality improvement initiative focusing on improving ED wait times, improving follow-up care, and enhancing patient-flow processes.
- Increase the rate of primary care and preventive care visits through the appropriate utilization of the medical home, simultaneously decreasing inappropriate use of the ER and the hospital.
- Obtain valid results for all core performance indicators for quality including those that are dependent on medical record review to create a year 1 baseline for quality.
- Implement focused initiatives to improve quality in targeted areas such as improved preventive screening rates for breast cancer and cervical cancer.

- Improve the coordination of care and information transfer across different Alliance care delivery sites, i.e., between ER and the primary care clinics, and between the clinics and the hospital.
- Evaluate and continue to enhance current disease management strategies for quality and effectiveness and work with the Alliance to enhance effectiveness of these programs.
- Evaluate the quality of hospital-based care through a defined set of indicators and through medical chart audits.
- Expand the focus of quality monitoring and improvement efforts beyond the primary Alliance partners to other contracted hospitals and clinics within the system.
- Conduct clinical studies describing the quality of care rendered to the population.
- Ensure that monthly onsite audits are performed.
- Ensure that monthly provider surveys are performed to document the positive and negative aspects of being a provider in this program.
- Link data reports to quality issues as much as possible (i.e., pharmacy reports to medications or disease categories).
- Continue the Quality of Care and ED Automation Meetings and encourage the increased participation of members to voice more recommendations.
- Continue to foster a partnership relationship with contractors so that the HCSNA staff is viewed as a resource rather than a monitor.
- Review and consolidate data reports submitted to the HCSNA as much as possible.

Access to Care

- Implement the community systems assessment review.
- Continue monitoring the provider network through monthly reports and biannual geoaccess mapping.
- Implement targeted initiatives to improve access in certain specialty provider categories such as dentistry.
- Ensure the implementation of a coordinated and collaborative system for appointment scheduling and tracking both for primary care, specialty care, and follow-up appointments post-discharge from the hospital or the ER.
- Develop a system for evaluating appointment wait times particularly for primary care and dental care services.
- Ensure periodic training of Alliance providers on eligibility requirements and the enrollment process by Chartered.

Use of Services

- Monitor service use by gender, age, ward, and overall for the enrollee population.
- Provide results to the Alliance to enable utilization management and outreach to underserved groups.
- Continue to monitor the distribution of members cared for by each Alliance vendor.
- Determine the ratio of patients to individual provider and track this measure.
- Determine the number of distinct members that received primary care and the referrals made for specialty care; monitor this trend.

- Assess service use by age group and disease condition for treatment planning and disease management.
- Profile frequent disease conditions to benchmark, implement best practices, and assess cost efficiency of vendor providers.

Physician Services

- Assist new members to select PCPs within the network that have the lowest patient to provider ratio.
- Continue to monitor physician services in the above categories and by medical home.
- Continue to monitor the ratio of the number of physicians to cost per service claim type.
- Conduct a focused study to determine the number of patients each PCP actually serves, and the number of referrals received by each member.
- Determine the number of patients each clinic actually cares for, the number of physicians allocated to provide care, the number of referrals and coordinated care, and the number of referrals received by each member.
- Review inpatient services provided by each physician, and evaluate on a case-mixed adjusted basis.
- Profile members with selected critical disease conditions by service category and medical home.

Inpatient Services

- Incorporate all provider claims, including services provided to the DOC members, in the claims database for accurate benchmarking.
- Identify the high-cost disease conditions for the first year; target the management goals and provide technical assistance for appropriate interventions.
- Continue to monitor the average length of inpatient stay by condition and provider and analyze by taking into account severity of illness.

Emergency Department

- Monitor the above ED use rates for comparison to national and regional benchmarks.
- Establish thresholds and goals for performance indicators, including frequency distribution for overall claims payment.
- Continue to seek appropriate benchmarks for level-of-service comparison.
- Incorporate all provider claims, including services provided through special settlements, in the claims database for accurate benchmarking.

Dental Services

- Continue to monitor use of screening and preventative services and the overall extraction service rates provided to Alliance members.
- Establish thresholds and goals for these performance indicators.
- Continue to monitor access to dental care and account for changes by comparison with the baseline service frequency distribution and national/regional benchmarks.

Pharmacy Services

- Extend weekday hours and weekend pharmacy access, increase the total number of Alliance pharmacies, and assess customer satisfaction through direct surveys.

Medical Homes

- Expand the current member satisfaction surveys to include medical home queries.
- Continue to educate Alliance members regarding their medical home.
- Define the medical home model for use with the Alliance population.
- Create the organizational infrastructure required to support medical home use.
- Define the services that will be provided by the medical home.
- Develop a plan to assess and coordinate services within each medical home and the surrounding community.
- Continue to educate providers on their role as a medical home provider.
- Empower medical home providers to perform prior authorization for referral services.
- Implement an expanded performance measurement system.
- Continue to measure medical home use by Alliance members.

Performance Improvement

- Implement strategies for improving access to services in certain specialty provider categories such as dentistry.
- Decrease Emergency Department wait times through enhanced patient flow processes and improved follow-up care.
- Increase the rate of primary care and preventive care visits through the appropriate use of the medical home.
- Decreasing inappropriate use of the ER and the hospital.
- Increase preventive screenings.
- Improve patient satisfaction with care provided through the Alliance.
- Enhance the process of data collection with a focus on indicators of health outcomes.
- Establish thresholds and goals for each of the performance indicators based upon baseline results and national/regional benchmarks.

Financial Performance

- Analyze the rate structure (compare with Medicaid managed care rates and individual provider rates for Medicaid).
- Conduct monthly financial reviews that lead to 6-month and annual reconciliation.

CONTRACTOR OPERATIONAL PERFORMANCE

- Develop a cohesive set of approved policies governing the operation of the Alliance. GSCH, Chartered, and Unity must work with the Alliance office to submit requested reports in a timely manner.
- Ensure staff is competent to perform care to the population at the level of expertise required.

- Ensure staff follows the policies and procedures of the facility in which they are employed to include good standards of care.

Alliance Member/Provider Satisfaction

- Develop a provider satisfaction component.
- Ensure corrections to customer service and provider satisfaction reporting systems.
- Ensure efficient documentation of all complaints, issues, praises, etc.
  Ensure that all complaints are documented and tracked for timely resolution.

GOALS FOR THE FUTURE

- Resolve the status of the DC General campus.
- Make the HCSNA the most efficient, cost-effective department in the DOH.